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change. Most of them are demonstrably sensory and could be traced through the posterior spinal ganglia to the cord, but some are as certainly motor. Afferent impulses from parts removed are of course impossible, but motor impulses overflowing from the cord to stumps, though only to be blocked at the site of amputation, are at least conceivable. The small fibres caused by general paralysis must be distinguished from Ranvier's small fibres constituting the neuroma and occurring at the end of the central stump of a cut nerve. The postero-lateral group is not sensory, but motor, innervating the muscles which maintain the erect position. Affection of the sensory tracts reduced the size of the posterior column and horn of the same side, but Clarke's columns were intact, their function being, as Gaskell has almost conclusively shown, the innervation of the viscera. All shrinking due to amputation is compensated by great widening of the lymph channels and slight increase of connective tissue in the small bundles.

Ueber Koprostatic-Reflex Neurosis. By Prof. E. H. KISCH. Berlin.
Klin. Wochenschr., April, 1887.

Neuroses of the heart are the most common of the reflex neuroses, which the author thinks to be due to habitual constipation. Next in order of frequency follow hemicrania. Then come sciatica, lumbar-abdominal neuralgia, ovaralgia, and the trigeminal neuralgia of Gussenbauer. The author feels justified in designating these as a distinct group of neuralgic affections due to defective action of intestinal ganglia, or in the terms in which Nothnagel summarized the results of his investigations, to "a diminution of the automatic activity of the nervous apparatus of the intestines."

Ueber die posthemiplegischen Bewegungsstörungen. Eine klinische Studie.
B. GREIDENBERG. Arch. f. Psychiatrie, 1886, p. 131.

This extended study, with very copious use of the literature of the subject collected in 267 titles at the end, in this new and fruitful field, is too crowded with details to be adequately reviewed. The main result reached by the author, not only from the literature but from careful study of cases, is expressed in the following table classifying post-hemiplegic movements:

Contractures	apoplectic, cramps, clonic	tonic	
		intermittent	
early	muscular rigidity	— paralytic, passive	
		late } constant, lasting, fixed	
late	changeable, (latent)		
exaltation of tendon reflexes			
co-ordinate movements			
tremors	reflex, clonus		
		essential } trembling proper (tremor) in	
hemichorea	constant } the form of paralysis agitans with intended movements, disturbance } of disseminate sclerosis		
athetosis			
		Composite forms in various combinations.	